



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE
Tuesday, March 4, 2014**

**HB 5378, An Act Implementing The Recommendations Of The Legislative
Program Review And Investigations Committee Concerning Medicaid-Funded
Emergency Department Visits**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5378, An Act Implementing The Recommendations Of The Legislative Program Review And Investigations Committee Concerning Medicaid-Funded Emergency Department Visits**. CHA supports the recommendations included in the bill, but has concerns about particular provisions as set forth below.

Before outlining our concerns, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

Generations of Connecticut families have trusted Connecticut hospitals to provide care we can count on.

CHA is pleased to have assisted Legislative Program Review and Investigations Committee staff in their efforts to examine emergency department utilization by Medicaid clients. We are grateful for having had the opportunity to facilitate visits by Committee staff to several hospital emergency departments, engage the providers of emergency medical care in conversations about these important issues, understand the various challenges facing hospitals across the state, and learn more about the steps being taken by hospitals and other healthcare and social service providers to address these challenges.

Each year, Connecticut hospitals treat more than 1.6 million patients in their emergency departments. Emergency departments are filled with individuals who cannot find a physician to care for them because they are uninsured or underinsured – or because they are Medicaid beneficiaries and few physicians or urgent care centers will accept the low rates paid by Medicaid. Throughout Connecticut, our emergency rooms are treating those who have delayed seeking treatment because of inadequate or no coverage and those who have no other place to receive care. Connecticut hospitals are the ultimate safety net providers.

Connecticut hospitals are absolutely committed to initiatives that improve access to high quality care, expand the availability of insurance coverage, and reduce healthcare costs. We are working to improve the quality of care by redesigning the Medicaid program, with a keen focus on patients and improving the care they count on.

Attached to this testimony is an outline of our proposal to redesign Medicaid. This outline was also submitted to the Appropriations Committee in our testimony on HB 5030, *An Act Making Adjustments To State Expenditures For The Fiscal Year Ending June 30, 2015*. In brief, our proposal is modeled on the Medicare Value-Based Purchasing program and incorporates those concepts into the Medicaid hospital payment system. The proposal aligns with the state's health reform agenda; builds upon the existing Medicaid Fee-For-Service payment system; focuses on programs to improve access to appropriate care, thereby reducing disparities and improving population health; uses quality metrics to track and reward change; and invests in hospitals that achieve the shared vision. This proposal includes processes and priorities for hospitals that are well established in the Medicare program. We believe that now is the time to apply the experience and success hospitals have had in improving care and outcomes for Medicare patients to the Medicaid program.

CHA supports the implementation of recommendations included in HB 5378 intended to increase primary care reimbursement, enhance patient-centered care, achieve continuous Medicaid eligibility, expand ways in which Medicaid clients may access specialty care, and require administrative services organizations (ASO) to offer intensive case management services.

Several Connecticut hospitals are already engaged in efforts to improve outcomes for frequent emergency department users. Programs that target ED "super-utilizers" (i.e., patients with complex, unaddressed health issues and a history of frequent encounters with emergency departments) demonstrate early promise of realizing the development of innovative care delivery models with the potential to improve care, improve health, and reduce costs.

CHA supports efforts to identify the ED super-utilizer subpopulations within the state, the factors that drive high utilization among these patients, and the feasibility of eliminating unnecessary utilization through a set of targeted interventions addressing the factors identified in each particular community.

The enactment of this bill will enable the state, through its ASOs, to play a key role by promoting and facilitating the discussion among healthcare and social service providers in each community to address their unique needs. Investing in care coordination resources will bridge the healthcare and social services continuum for their Medicaid clients, thus better managing Medicaid costs.

These measures will also incent and encourage collaboration among state government, hospitals, and other healthcare and social service providers to achieve improved healthcare outcomes for all patients.

Predictability and stability in Medicaid eligibility for children and adults will ensure that patients receive primary and preventative care to keep healthy, and help providers maintain long-term relationships with their patients. CHA supports Section 7, which provides for 12 months of continuous eligibility for children, and Sections 8 and 9, which require the Commissioner of Social Services to seek federal approval for 12 months of continuous eligibility for all adult Medicaid recipients.

While CHA supports most of the measures included in the bill, we are concerned about the following provisions.

Section 1(b) requires that any contract entered into with an administrative services organization include a cost sharing requirement. As drafted, this section is unclear regarding the cost sharing requirements. If the provision is referring to the cost sharing requirement that was enacted last session, it is important to note that CHA opposed that requirement as it may prevent vulnerable, low-income individuals from obtaining appropriate services. In addition, we had concerns that depending on how such a provision was implemented, it could impact a hospital's obligation under the Emergency Medical Treatment and Labor Act (EMTALA), which requires a medical screening for everyone who comes to the ED, regardless of their ability to pay. If the cost sharing requirement is not on Medicaid enrollees, we look forward to working with the Committee to understand the requirement and how it will be implemented.

Included on the list of intensive case management services set forth in Sections 1(b) and 2(c) is the creation of follow-up care plans for Medicaid clients. CHA wishes to highlight the distinction between a "follow-up care plan" administered by an insurer, managed care company, or ASO, which is typically based on utilization data, and a "clinical care plan" developed by a licensed and qualified medical professional based on medical consultation with a patient, and specifically geared toward addressing the patient's healthcare needs.

Finally, CHA is concerned about the language in Section 4(f) expanding the Commissioner's ability to implement policies and procedures in advance of adopting regulations. We recognize the desire to implement policies and procedures in a timely manner; however, we believe that the authority to act outside the Administrative Procedures Act should be used sparingly. Compliance with the Administrative Procedures Act will ensure that input may be provided by the public, consistent with the principles underlying sound administrative procedures.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

A Proposal to Implement a Medicaid Value-Based Hospital Payment System and Phase Out the Hospital Tax Over Five Years

November 26, 2013

Principles for a Medicaid Hospital Value-Based Payment System

- Our efforts should:
 - Align with the state’s health reform agenda.
 - Build upon the existing Medicaid FFS payment system.
 - Focus on programs to improve access to appropriate care thereby reducing disparities and improving population health.
 - Use quality metrics to track and reward change.
 - Implement new payment methods to incentivize hospital change.
 - To the extent practical, use the methods and processes developed for Medicare.

Initial Areas of Focus for Hospital-Value Based Payments

- DSS/CHN identified priorities:
 - ✓ Reduce avoidable ED visits
 - ✓ Reduce readmissions
 - ✓ Intensive care management (ICM)
 - Asthma, Diabetes, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)
 - ✓ Inpatient discharge care management programs (ICDM)

Hospital Value-Based Concept to Action

How to Convert Hospital Value-Based Principles and Priorities to Incentives

Medicaid Hospital Value-Base Payment Structure

- **Member Priority Program (MPP)**
 - The MPP has two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM); the Medicare analog is Pay-for-Reporting.
- **Hospital-Community Connection Program (HCCP)**
 - The HCCP has two elements: Participation in CHN's Inpatient Discharge Care Management Program (ICDM) and Intensive Care Management Program (ICM), and performance measurement; the Medicare analog is Pay-for-Performance.
- **Hospital Reporting Program (HRP)**
 - DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

Member Priority Program (MPP)

- MPP Essentials
 - Hospital payment rates are annually updated by the Medicare Market Basket update beginning July 1, 2014.
 - To be eligible for the full update, hospitals must provide timely ED and inpatient admission notification as well as HEDIS reporting data; method and frequency to be determined.
 - Hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data will have their payments updated by the Medicare Market Basket less 2 percentage points.

Hospital-Community Connections Program (HCCP)

- HCCP Essentials
 - The HCCP is dynamic with incentives and program structure changing over time as the program and experience matures.
 - Beginning July 1, 2014 hospitals are annually eligible for a share of a supplemental Pay-For-Performance payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
 - A hospital's share of the funds shall be calculated as its attainment score x share of expenditures x the supplemental pool.
 - An attainment score is the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 66%.

Hospital-Community Connections Program (HCCP)

- HCCP (continued)
 - Year 1, July 1, 2014 - June 30, 2015, hospitals will earn 1% each for: participation in the CHN Inpatient Discharge Care Management Program (ICDM), Intensive Care Management Program (ICM), and a stabilization/reduction in statewide Plan All-Cause Readmission rates.
 - Year 2 and 3, July 1, 2015 - June 30, 2017, hospitals will earn .5% each for: participation in ICDM and ICM; and .5% each for stabilization/reduction in statewide rates for: Plan All-Cause Readmission, COPD Admission, CHF Admission, and Adult Asthma Admission.

Hospital Reporting Program (HRP)

- HRP Essentials
 - By December 31, 2013 DSS/CHN/CHA will agree on the content and frequency of performance reporting.
 - By March 1, 2014 DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
 - By July 1, 2014 DSS/CHN/CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.

Phasing Out the Hospital Tax: Concept to Action

How to Phase Out the Hospital Tax Over Five Years

Phase Out of the Hospital Tax 2015 to 2019

(in Millions)

	Hospital Payments	Hospital Taxes	Net Benefit to Hospitals	Net Benefit to State
2011	83	0	83	(42)
2012	400	350	50	150
2013	323	350	(27)	189
2014	249	350	(102)	275
2015*	99	350	(251)	320
2015**	79	300	(221)	276
2016**	53	220	(167)	204
2017**	27	140	(113)	132
2018**	14	60	(46)	56
2019**	0			

(794) 1,561

* Current law ** Proposed

An Act Concerning Implementation Of a Medicaid Value-Based Hospital Payment System

Whereas the State has identified a number of priorities in order to improve care to patients and reduce costs to taxpayers; and

Whereas these priorities include (a) reducing the number of avoidable emergency department visits; (b) reducing the number of hospital readmissions; (c) better management of chronic conditions such as asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease; and (d) better management of patients following discharge from the hospital; and

Whereas the State has determined that the best means of accomplishing these priorities is to establish certain hospital value-based reimbursement principles;

Therefore, we are enacting the following provisions to assist in the achievement of these priorities.

Section 1. Definitions.

- (a) Member Priority Program (MPP). The MPP consists of two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM).
- (b) Hospital-Community Connection Program (HCCP). The HCCP consists of two elements: Participation in the Department of Social Service's Inpatient Discharge Care Management Program IDCM and Intensive Care Management Program (ICM), and performance measurement.
- (c) Hospital Reporting Program (HRP). The HRP is data DSS shall provide to hospitals which will include but not be limited to Continuity of Care Document (CCD), summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
- (d) Department of Social Services (DSS). DSS shall mean the department, its commissioner or designated agents.

Section 2. The MPP

- (a) Hospital payment rates shall be annually updated beginning October 1, 2014, by the Inpatient Prospective Payment System (IPPS) Hospital Market Basket as published annually by CMS in the Federal Register. To be eligible for the full amount of the update, hospitals must provide timely Emergency Department (ED) and inpatient admission notification as well

as HEDIS reporting data, in a manner and frequency as determined jointly by DSS and The Connecticut Hospital Association.

- (b) Payments to hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data shall be updated by the Medicare Market Basket less 2 percentage points.

Section 2. HCCP.

- (a) Effective July 1, 2014, hospitals shall be annually eligible for a share of a supplemental HCCP payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
- (b) An attainment score is defined as the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 67%.
- (c) A hospital's share of the funds shall be calculated by multiplying its attainment score times its share of expenditures times the amount in the supplemental pool.
- (d) Effective July 1, 2014 through June 30, 2015, hospitals shall earn 1% each for: participation in (1) the Inpatient Discharge Care Management Program (IDCM), (2) the Intensive Care Management Program (ICM), and (3) a program to stabilize and reduce statewide Plan All-Cause Readmission rates.
- (e) Effective July 1, 2015 through June 30, 2017, hospitals shall earn (1) a potential one percent of the pool as follows: one half of one (.5%) percent each for: participation in IDCM and ICM; and (2) a potential two percent for the pool as follows: one half of one (.5%) percent each for stabilization/reduction in statewide rates for (i) Plan All-Cause Readmission, (ii) COPD Admission, (iii) CHF Admission, and (iv) Adult Asthma Admission.

Section 3. HRP.

- (a) By June 1, 2014 DSS and CHA will agree on the content and frequency of performance reporting; and
- (b) DSS shall provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

- (c) By July 1, 2014 DSS and CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.